

**AUTHORIZATION TO RELEASE INFORMATION**

To: M.C.C.

I hereby authorize the above-named person or entity to release the information described herein to my attorney LYNN H. BALL, or any duly authorized agent of Lynn H. Ball, 1560 Scott Street, San Diego California 92106, 619-225-1914.

I hereby request and authorize the release of any or all of the following records:

☒ Medical records, including the laboratory reports, chart notes, emergency room records, etc.

☐ Psychological and/or psychiatric records, including progress notes and reports and/or any other patient records.

☐ Employment records and/or time records.

☐ Laboratory results and test records.

☒ Medical reports, including medical history, findings, diagnosis and prognosis.

☐ X-ray plates and radiology records, scans, films, photos.

☐ \_\_\_\_\_  
\_\_\_\_\_  
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I hereby release the provider of the requested records from all legal liability that may arise from the release of this information by the party named above. A copy of this authorization shall be considered as effective and valid as the original.

Dated: April 08

X Adriana Vazquez  
Person Authorizing Release  
DOB:  
S.S. #: